

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4938HIC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/29/2008
NAME OF PROVIDER OR SUPPLIER FLEURDELIZ		STREET ADDRESS, CITY, STATE, ZIP CODE 7460 PALMYRA STREET LAS VEGAS, NV 89117		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	<p>Initial Comment</p> <p>This Statement of Deficiencies was generated as the result of a State complaint survey conducted at your facility on 10/28/08 and 10/29/08.</p> <p>This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>Complaint #NV00015824 was Unsubstantiated.</p> <p>There were no deficiencies found during the survey. No further action is necessary concerning this report. Please retain this copy for your records.</p>	H 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE